Virginia Department of
Health Professions
Board of Pharmacy

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www.dhp.virginia.gov/pharmacy

APPLICATION FOR A PHARMACY PERMIT

Check Appropriate Box(es):

☐ New[3]	$270.00	☐ Change of Pharmacist-In-Charge[2]	$50.00
☐ Change of Ownership[2]	$50.00	☐ Change of Location[3]	$150.00
☐ Change of Pharmacy Name[2]	No Fee	☐ Remodeling of Prescription Dept.[3]	$150.00
☐ Reinstatement[1, possibly 3]			

[1] If reinstatement, due to: ☐ Lapse of Permit or ☐ Suspension or Revocation of a Permit

Application fees are not refundable. Applications are valid for one year from the date of receipt. The required fees must accompany the application. Make check payable to "Treasurer of Virginia".

Please provide the information requested below. Send ORIGINAL application to the Board for processing.

Name of Pharmacy	Area Code and Telephone Number	
Street Address	Area Code and Fax Number	
City	State	Zip Code
If a current pharmacy permit is held, indicate the permit number **0201-**	Telephone Number (currently working number)	
(Print) Name of the Pharmacist-In-Charge (PIC) (if change of PIC, list incoming)	License Number of the PIC **0202-**	
Signature of the Pharmacist-In-Charge (PIC) (if change of PIC, incoming signature)- By affixing my signature I acknowledge that I have read and understood guidance document 110-27 and associated information regarding the inspection process.	[2] Effective Date of Change (if change of PIC, date assuming role as PIC)	
	Date	Email Address of Pharmacist-in-Charge
Expected Hours of Operation	Expected Opening, Moving, or Completion Date	Requested Inspection Date [3]

[3] A 14-day notice is required for scheduling an opening or change of location inspection. Drugs may not be stocked prior to inspection and approval. An inspector will call prior to the requested date to confirm readiness for inspection. If the inspector does not call to confirm the date, the responsible party should call the Enforcement Division at 804-367-4691 to verify the inspection date with the inspector.

FOR OFFICE USE ONLY:

Date processed:	Check No:	Receipt No:		Application No:
Assigned Inspection Date:	Date Inspected:	Reviewed By:	Date Reviewed:	Date Issued:
Permit Number **0201-**	USP or cGMP:	Date Scanned to Enforcement:		

OWNERSHIP TYPE—check one: Corporation ☐	Partnership ☐	Individual ☐	Other ☐
Name of ownership entity if different from name of application:			
Street Address:			Phone No.
City:	State:		Zip Code:
State(s) of incorporation:			

List all other trade or business names used by this facility

Name: _____ **Name:** _____

Name: _____ **Name:** _____

LIST OF OWNERS/OFFICERS AND RESIDENCE ADDRESSES, OR LIST IS ATTACHED ☐

Name: _____ Title: _____

Residence Address: _____

Name: _____ Title: _____

Residence Address: _____

LIST OF PHARMACISTS PRACTICING AT THIS PHARMACY OTHER THAN PIC OR LIST IS ATTACHED ☐

Name: _____ License No. **0202-**

Name: _____ License No. **0202-**

Name: _____ License No. **0202-**

Please answer the following questions:

1. Does the pharmacy engage in the **HIGH-RISK** compounding of sterile drug products?	Yes ☐ No ☐
2. Does the pharmacy engage in the **MEDIUM-RISK** compounding of sterile drug products?	Yes ☐ No ☐
3. Does the pharmacy engage in the **LOW-RISK** compounding of sterile drug products?	Yes ☐ No ☐
4. Does the pharmacy engage in the compounding of **NON-STERILE** drug products?	Yes ☐ No ☐
5. Does the pharmacy share or intend to share the same physical space with an outsourcing facility? If yes, all compounding must be performed in compliance with cGMPs and the facility must also obtain a permit as an outsourcing facility.	Yes ☐ No ☐